On three occasions in which he has excised the gall-bladder, it has been for mucous fistula depending on stricture of the cystic duct following on gall-stones, and all the cases were completely and permanently relieved.

Cholecystectomy can seldom be advisable or necessary as a primary operation in gall-stones, and extremely rarely possible in malignant disease. In cholecystotomy, where it is impossible to bring the margins of the incised gall-bladder into the wound, and where the parietal peritoneum cannot be tucked down to meet the edges of the opening, he has made a tube of the omentum, but in such cases no hesitation need be felt in trusting to a drainage-tube, as the peritoneal cavity soon becomes occluded around the drain, and there is little or no tendency to the passage of bile among the viscera, so that a suprapubic drainage opening is quite unnecessary. With very few exceptions he has found a vertical incision along the upper part of the right linea semilunaris to give ample room, but if required he has not hesitated to get further room by a transverse cut in addition.

Suture of peritoneum, aponeurosis, and skin by separate stitches effectually guard against ventral hernia, if the patient be kept recumbent for from twenty-one to twenty-eight days, and if a firm oval pad be worn under a belt for a few months subsequently.—*Brit. Med. Journ.*, April 28, 1894.

II. New Method of Jejunostomy. By Professor ALBERT (Vienna). During the year 1888 two jejunostomies were performed in Professor Albert's clinic. In the first case the patient lived four weeks after the operation; in the second case the patient died of pneumonia on the fourth day. Maydl has performed the operation once, at which time he did a simple lateral jejunostomy,—sewing the gut into the abdominal wound and opening it. In 1892 he published a new method of performing the operation (*Wiener medicinische Wochenschrift*, Nos. 18 and 19, page 742). The loop of jejunum being drawn out through the abdominal wound was divided transversely. The distal end was then drawn out still farther and an opening made

lower down, into which opening the proximal end of the gut was sutured. By this means the secretions of the pancreas and liver passed on into the intestine. The transverse wound of the distal end was then sewed into the abdominal opening, through which the food could be introduced. A regurgitation of the intestinal contents could not easily occur. He employed this same idea in gastro-enterostomy, the end of the distal segment being implanted in the stomach.

Albert (*Wiener medicinische Wochenschrift*, No. 2, 1894, page 58) reports a method which he has employed more recently, and which seems to him somewhat simpler than the preceding procedure.

The patient was a woman twenty-nine years of age, who had suffered thirteen years before with peritonitis, but otherwise had been healthy. For the last two years she had suffered with stomach trouble, marked by frequent vomiting. For six months she had also complained of pain in the abdomen. She was delicate, anæmic, and weak. A tumor the size of the fist could be felt above the navel. It was placed transversely, was firm, moved up and down with the diaphragm, and was separated from the liver by a tympanitic zone. It was evidently a carcinoma ventriculi of unusual size, the removal of which was out of the question. Because of the extensive involvement of the stomach wall a gastro-enterostomy was also contraindicated, and a jejunostomy was performed. On opening the belly a carcinoma of the pylorus was found extending along the lower curvature to the fundus. A loop of jejunum was drawn out, and the larger part of the abdominal wound temporarily sutured. The gut was not cut across, but an anastomosis was made at the base of the loop between the distal and proximal sections for the transmission of the secretions of the liver and pancreas. Parallel to the first abdominal incision, and four centimetres above it, a second incision two centimetres long was made through the skin. Between these two wounds the skin was undermined so that a bridge of skin was formed. The loop of jejunum was then dragged under this bridge and sutured to the edges of the upper wound. The skin was sutured entirely over

the lower wound, leaving the gut with a skin covering. The anastomosis lay directly behind the peritoneal wound in the abdominal cavity. The distal arm of the loop passed in a direct line from the upper wound beneath the skin and back into the abdomen. When necessary, regurgitation could be prevented by placing a compressing-pad over the skin between the two wounds.

On the fourth day after the operation the intestine was opened with the cautery. The patient was fed with milk, soup, wine, eggs, etc., and discharged at the end of three weeks. Eight weeks after the operation she died. She had continued to feed herself by the fistula and by mouth.

Albert has performed a second such operation. The patient was a woman twenty years of age, who had suffered from contraction of the œsophagus and stomach after swallowing lye about a month before. She was so weak that she perished a few hours after the operation. The autopsy showed extensive ulceration of the stomach and stenosis of the pylorus. Albert is of the opinion that this method is more easily carried out than the operation of Maydl, and will find application especially in such cases as the last.

JAMES P. WARBASSE (Brooklyn).

III. A Case of Perforation of a Chronic Ulcer of the Duodenum Successfully Treated by Excision. By HENRY PERCY DEAN, F.R.C.S. (London). A married woman, aged twenty-seven years, was admitted into the London Hospital, February 17, 1894, with intense pain over the whole of the abdomen, perhaps slightly more marked in the epigastric regions: the patient felt very ill, and her expression was exceedingly anxious. Vomiting occurred every few minutes. The pulse was 120, feeble and regular. The respirations were rapid and irregular, both in force and rhythm. The tongue was slightly furred and very dry. There was uniform tenderness over the entire abdomen, the distention was moderate in degree. The temperature was 100.6° F.

For about a fortnight she had suffered from pain in the chest and